

MONONGAHELA VALLEY HOSPITAL
MVH CARE APPLICATION

Please attach proof of income from the past 30 days to this application. Please verify all income listed in Section One and Section Two. If you are unable to verify some or all of your income, please explain why on an attached sheet of paper. Applications will not be rejected for inability to verify income, provided that reasonable explanation for the inability is given.

- Pay stubs or letters from employers, listing wages before taxes.
- Award letters or bank statements showing deposits of Social Security, other disability, pension, worker's compensation, or unemployment compensation payments.
- Award letters, court documents, or bank statements showing deposits of child or spousal support payments.
- Documentation of other sources of income.
- If the household has no income, letters from persons who are assisting with daily living needs, explaining the help that the persons provide (e.g., grocery purchases or rent and utility payments).

Please complete all questions in this section. Failure to complete this section could result in delays in evaluating eligibility for MVH Care.

Patient Information

Patient Name: _____ Date of Birth: _____

Street Address: _____

City/State/Zip: _____

Home Telephone: _____ Work Telephone: _____

Preferred calling time: _____

Form Rev. 12-09

Household Members:

Please attach additional sheets of paper if household has more than eight members.

	Name	Relationship:	Age:
1.	_____	self	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____
8.	_____	_____	_____

GUARANTOR/PATIENT NAME:

MVH ACCOUNT #: _____ BALANCE: _____

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TOTAL BALANCE (ALL ACCOUNTS): _____

1. HOUSEHOLD INCOME (MONTHLY)

A. Wages

- 1. Total wages of patient/guarantor: _____
(Attach copy of paycheck stub)
 - 1a. Employer Name: _____
 - 1b. Employer Address: _____
- 2. Spouse's Name: _____
 - 2a. Total Wages of Spouse: _____
(Attach copy of paycheck stub)
 - 2b. Spouse's Employer Name: _____
 - 2c. Employer Address: _____

II. OTHER INCOME

- Pensions:** _____ **Social Security:** _____
- Other Disability:** _____ **SSI:** _____
- Cash Assistance:** _____ **Unemployment Comp.:** _____
- Worker's Comp.:** _____ **Child Support:** _____
- Spousal Support:** _____ **Other (Please explain):** _____

III. TOTAL MONTHLY INCOME: \$ _____

IV. HOUSEHOLD ASSETS

- 1. Real Property/Residence/Other
 - 1. Address: _____

 - 2. Rent _____ Own _____
 - 3. Market Value: \$ _____
 - 4. Mortgage Balance: \$ _____
 - 5. Net Value Property: \$ _____

(IV. HOUSEHOLD ASSETS CONT.)

6. Mortgage Bank: _____
Address: _____

2. Automobile:
1. Make: _____ Model: _____ Year: _____
2. Loan Balance (Principle): \$ _____
3. Loan Balance: \$ _____
4. Net Value: \$ _____

3. Other Assets (At Market Value)
1. Savings Account Number: _____
a. Balance: \$ _____
2. Checking Account Number: _____
a. Balance: \$ _____
3. Certificate of Deposit Bank Name: _____
a. Balance: \$ _____
4. Insurance Cash Value: \$ _____
5. Stocks, Bonds, Other:
a. Source: _____
b. Cash Value: \$ _____

ALL OF THE INFORMATION IS TRUE AND COMPLETE, AND MAY BE VERIFIED WITH THE LISTED INSTITUTIONS. I REQUEST EACH LISTED INSTITUTION TO RELEASE ALL OF MY PERSONAL ACCOUNT BALANCE INFORMATION TO MONONGAHELA VALLEY HOSPITAL IN ORDER TO VERIFY THE BALANCES/AMOUNTS LISTED.

Date

Signature of Applicant

FOR HOSPITAL USE ONLY

TOTAL NET SCHEDULED ASSETS \$ _____

Optional Questions

If you so choose, please answer the questions below to provide a better understanding of your ability to pay for medical care. Higher-than-average or otherwise unusual expenses may result in an adjustment of income downward. Lower-than-average expenses will not result in an adjustment of income upward.

Monthly Household Expenses

Mortgage/Rent: _____ Property Taxes: _____
Insurance: _____ Auto Loan: _____
Credit Cards (Total): _____ Water: _____
Gas: _____ Oil: _____
Electric: _____ Telephone: _____
Child Support: _____ Spousal Support: _____
Other (Please Explain): _____

Monthly Medical Expenses

Insurance Premiums: _____ Equipment: _____
Doctors' Visits: _____ Prescriptions: _____
Other (Please Explain): _____